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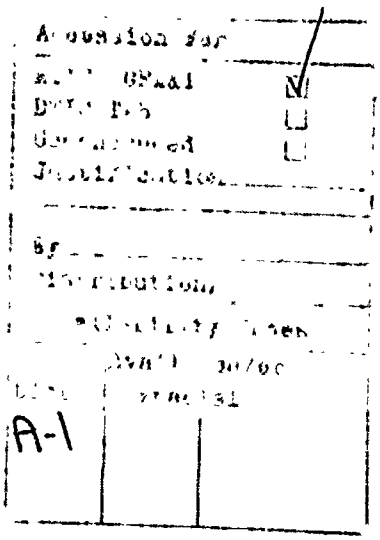

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Mentorship has been used as a career and personnel development tool in business for years. Mentorship is only a recent phenomenon in nursing. Research has proven that there are many benefits that can be reaped from a mentorship relationship by the protege, mentor, and organization. But with all mentorship relationships, there can be selection, outcome and process problems that must be addressed for the relationship to be successful. There are many models of mentorship found in the literature. But the nursing has often confused mentorship with preceptorship and role modeling. Also, the models described do not fit within all levels of nursing practice. For these reasons, the author developed a mentorship model that could be used at any level or in any practice setting. The model has many implications for the Nurse Administrator. The ability of the Nurse Administrator to handle the implementation of the model will ultimately determine its success. Mentorship can have a tremendous impact on nursing recruitment, retention and image. Mentorship could be a gateway to the future of the profession.

Mentorship: A Model for Nursing

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Mentorship: A Model for Nursing

Jill D. Dixon

University of Maryland, Baltimore

Seminar Paper submitted to the faculty of
the Graduate School of the University of Maryland
at Baltimore in partial fulfillment of
the requirements for the degree of
Master of Science, 1991

Introduction

The term "mentor" has its roots in Greek mythology. In Homer's Odyssey, Mentor was a counselor, teacher, advisor, protector, and guide to Telemachus during his search for his father, Odysseus. Even after finding his father, Mentor continued to inspire and influence Telemachus, thus the term "mentor" evolved. A mentor is a person that teaches, counsels, guides, encourages, and supports an individual through life.

Mentoring has different meanings to different authors and professions. In business, a mentor oversees the career and development of another person, usually a junior, by teaching, counseling, providing psychological support, protecting, and at times promoting or sponsoring them. A mentor is someone in a professional or managerial position who functions as a career coach. The mentor guides and teaches the protege the cultural aspects of the organization. The mentor corrects the protege if mistakes are made and gives him/her inside company information. A mentor can be involved in a formal program providing one-to-one interaction with a protege or initiate an informal relationship by identifying promising employees. Also

there is a broad perception that to be successful you must have a mentor. In the medical profession, the mentor takes on the form of an advisor versus a teacher.

In nursing, mentorship is often defined the same as in the business world. But authors still refer to mentors as preceptors, role models, mother surrogates and best friends. Mentorship has been equated to a preceptorship and internship. Mentorship is at one end of a continuum, preceptorship is in the middle, and internship is at the other end. Their differences are related to the length and intensity of the relationship with mentorship being the longest and most intense.

Nursing administrators play a key role in defining mentorship in nursing and fully developing the role. They must educate others about the importance and critical differences a mentor could have in the development, the recruitment and the retention of nursing professionals. This author will develop a model specific to nursing and its unique needs. It will be practical, easily applied to all clinical areas and roles and readily understood by those using it.

Chapter 1

REVIEW OF LITERATURE

Mentoring plays a vital role in the educational and professional development of many professionals. It has been more formally developed in the business world over the last 10 to 15 years, although the J.C. Penny Company has educated their store managers through mentorship since 1901 (Davidhizar, 1988). In business, most individuals believe to be successful they must have a mentor or face a mundane existence.

The Role of the Mentor

Zey (1984) describes a hierarchical approach to the mentoring process. The four mentoring activities - teaching, psychological counseling/personal support, organizational intervention, and sponsoring are arranged according to the relative contribution each plays in the protege's professional development and career advancement.

In the first level, the protege learns the necessary job performance skills, including personnel and organizational culture management. The mentor imparts information on current professional trends and gives the protege a conceptual professional base to use

during business interactions. The mentor helps the protege gain proficiency through role participation, questioning of actions or non-actions, and encouraging the protege tc learn via the trial and error method. Lastly, during the teaching phase, the mentor presents career paths inside and outside the organization, encourages advanced degrees and can redirect the protege into a suited career field. Burke (1984) found that mentors provide proteges with a better understanding of the organization. The mentor must be a highly competent individual to provide this function. Also the protege and mentor must be compatible to permit this exchange of information.

The second, personal support level involves confidence building, pyschological assistance, and advice about or intervention in the protege's personal life. The mentor shows faith in the protege without seeming patronizing, provides support to help the protege overcome the job's stresses and strains and gives advice about handling family pressures and problems, personal dilemmas, and conflicts that interfere with the protege's job performance (Zey, 1984). Burke's (1984) research supports Zey's model.

Mentors increase the protege's self-confidence, provide insight into the protege's behavior, and provide different approaches to work methods and problem solving. To avoid conflicts, the degree of personal support must be mutually agreed upon by the participants.

In the third level, organizational intervention, the mentor helps the protege gain access to resources through protection and by surrounding him/her with a supportive environment, including mediation in conflicts and situations that can potentially harm the protege's career. The mentor markets the protege through increased visibility within and outside the organization by transmitting his/her attributes to senior management. This establishes the protege's legitimacy and credibility. Finally, the mentor affords access to money, resources, and supply and communication lines that may not otherwise be available to the protege's due to rank or limited knowledge on attaining them (Zey, 1984). The mentor and protege must mutually determine the degree of organizational intervention needed for appropriate and successful career progression. If the mentor is overprotective,

the protege will never learn to perform these functions on his/her own.

Sponsorship of the protege, the fourth level, the mentor directly promotes, increases the protege's title, expands his/her function in the organization, and manipulates the organizational political factors. Through indirect sponsorship, the mentor gains admission to in-house training programs and key management programs for the protege, and assists him/her in obtaining important appointments to trade magazines, professional journals, or boards (Zey, 1984). If the protege relies too heavily on the mentor, he/she will never be able to function as an adult with others. There will always be a dependence on the mentor for advancement instead of on his/her own abilities. Many authors agree with these mentoring functions, but did not place them in a hierarchical model (Farren, Gray, and Kaye, 1984; Klauss, 1981; Lea and Leibowitz, 1983; Ross, 1984).

Fagenson (1988) reported that mentored individuals felt they had more organizational policy influence, greater access to important people, and greater resource power. Jacoby (1989) stated a mentoring

program could decrease costs through recruitment of talent from within the organization instead of outside, decrease turnover, and produce greater employee contribution to the organization.

In Zey's (1984) Mutual Benefits Model, the protege, mentor, and organization have mutual benefits. The protege learns his/her job and related political and cultural aspects of the organization. The mentor has help doing his/her job, has a source of organizational information and intelligence, and has a trusted advisor. Also, the attention the protege's accomplishments receive can have a positive effect on the mentor's reputation. Through the relationship, the organization has a smooth functioning managerial team, an appropriately socialized and integrated employee, and most importantly, a distinct model of managerial succession guaranteeing the transference of organizational values and culture to the next generation of managers. The model depicts a three-way interrelationship between the mentor, protege, and organization, showing the benefits exchanged between the mentor and protege and between the mentor-protege relationship and the organization.

Risks of Mentorship

Although the benefits are many, mentor-protege relationships do incur many risks. Myers and Humphreys (1985) placed the risks into three categories: 1) selection, 2) outcome, and 3) process. Selection problems encompass various methods by which mentors and proteges are chosen. These include preselection, "old-boy" networks, nepotism and blatant discrimination. These problems are of particular interest for the organization if minorities and women are involved.

Outcome problems involve the failure or success of the mentor and protege. Some examples include: guilt by association with a failed mentor or "black halo" effect (Gite, 1988; Zey, 1984); a role reversal with the protege being more successful than the mentor; and a mentor who becomes sidetracked and stalls or halts the protege's career. Problems also develop if a mentor will not develop and/or promote the protege to a position higher than theirs or one outside the mentor's control and influence. The mentor who is an unfair advocate for a protege and denies the rights of others is a problem (Myers & Humphreys, 1985).

Process problems involve the relationship between

the protege and mentor. These include incompatible personalities, using the protege as a "errand boy or girl" and overburdening the protege with distasteful tasks. Also, an individual who is very successful career-wise but becomes a "bully" in the mentor role, or the mentor who deliberately teaches the protege incorrect or dishonest procedures, or retards and oppresses a protege's progress are process problems.

The most difficult process problems to manage involve cross-gender and cross-racial mentoring. These mentoring relationships demand the manager's special attention and effort to achieve success.

In cross-gender mentoring, a "developmental dilemma" develops if the mentor and protege do not avoid an intimate male-female relationship. A boundary between the appropriate levels of romantic involvement and intimacy must be established. If the boundary is crossed, integrity must prevail in the resolution. The internal relationship between the mentor-protege pair and the external relationship between the pair and the organization and public must be handled effectively, as well as the conclusions, proven or not, drawn by others about the actual level of intimacy between the pair.

If cross-gender mentoring is managed appropriately, it can contribute a great deal to the personal and professional development of the mentor and protege, as well as to the organization (Clawson and Kram, 1984).

Reich (1986) discovered that 99% of women versus 87% of men gained more self-confidence and an enhanced awareness of their strengths through the mentor-protege relationship. Burke (1984) found that women were more likely to have a female versus a male mentor and male mentors had more career influence on female proteges than on male proteges. Noe (1988a) found mentors matched with proteges of the opposite sex had a more effective relationship than proteges of the same sex.

The cross-racial mentoring issues are rooted in the historical aspects of the relationship between blacks and whites and especially those of the opposite sex. The racial "taboos" have the potential for interfering in the development of minority mentoring relationships. Thomas (1989) rank ordered the power the taboo had on the relationship. The white male mentor/black female protege pair elicited feelings that the white man had unlimited sexual access to the black woman. The black male mentor/white female protege pair

elicited feelings that the black man was making sexual advances toward the white woman. The white male mentor/black male protege pair evoked feelings that the white male was "freeing the slave" and was posing a threat to other white men. The white female mentor/ black female protege pair elicited feelings that the black woman was abandoning the black man, but this was counterbalanced by the shared experience of womanhood. Open communication channels and organizational support may help eliminate these feelings, but more must be done. Thomas suggested that a social technology must be developed to assist "blacks and whites more directly confront their history and the present."

Stages of Mentorship

The mentor-protege relationship does not occur instantaneously. Kram (1983), Hunt and Michael (1983), and Dalton, Thompson, and Price (1977) and Ross (1984) describe models that have developmental phases in which the relationship should progress.

Career Training and Development Models

Hunt and Michael (1984) and Kram (1983) describe a four stage model: initiation, cultivation/protege, separation/break-up and redefinition/lasting

friendship. In the initiation phase, which lasts six months to a year, the mentor and protege select and get to know one another. Either, the protege selects a competent, senior individual who has the ability to provide support, guidance and career advancement; or the senior individual chooses a promising protege who is coachable and enjoys work. As the protege and mentor connect, their relationship and roles are defined. Burke (1984) found in early career development, 59% of men and women felt the relationship was spontaneous and the mentor more often instigated the relationship. If an individual is unable to find a mentor suited to them, selection problems could result, and a promising employee could be under or undeveloped.

The cultivation phase, lasting two to five years, is when the positive expectations of the first phase are tested against reality. The relationship's boundaries are clarified and the first phase's uncertainty is no longer present. During this phase, the mentor provides career functions that prepare the protege for career progression and pyschological functions that enhance the protege's sense of competence (Kram, 1983). If the mentor does not stay

up to date on current trends and technologies, the protege's career progress could be adversely affected. But if the opposite is true, the protege could have an invaluable resource to future trends in the profession.

Hunt and Michael (1983) named this the protege phase during which the individual improves his/her skills. The mentor begins to recognize the individual as a protege, not an apprentice. The protege's work is viewed as by-products of the mentor's instruction, encouragement, support and advice. But as the protege grows emotionally and professionally in this phase, he/she forms a need for individuality in regards to his/her work being known on its own merit. The mentor and protege must determine the level of involvement needed in the relationship for it to be successful.

As the relationship matures, it progresses to the separation stage (Kram, 1983) which occurs six months to two years after a significant change in the relationship. In this stage, the protege seeks more autonomy and independence and the mentor and protege are evaluating the relationship's purpose and value in the job setting. The structural and psychological separation should occur simultaneously to ensure that

the protege can perform effectively without close guidance or supervision. If the structural separation occurs first, the protege can experience anxiety from being compelled to function independently before feeling emotionally ready. Also, the protege feels abandoned by the mentor and unprepared for the future. If the psychological separation occurs first, the mentor and protege can feel resentment toward each other because neither person's emotional needs and concerns are met. Regardless of how the separation occurs, this is a critical adaptation period for both the mentor and protege because the career and psychosocial functions can be modified or lost. Kram felt a dysfunctional relationship can result if the mentor is unable to separate emotionally when the protege is eligible for promotion. If these changes occur successfully, the mentor-protege relationship will be redefined.

Hunt and Michael (1983) described the break-up stage as an emotionally charged event. It occurs if the mentor will not accept the protege as a peer or is not emotionally prepared to handle the protege's need for autonomy and independence. It most often occurs

with a physical separation when the protege is promoted or takes a position in another division, organization or location. Also, the break-up can occur from total loss of interest in maintaining contact.

The redefinition/lasting friendship stage is the final phase. It is an indefinite period when the relationship is ended or takes on significantly different characteristics, resulting in a more peerlike friendship (Kram, 1983; Hunt and Michael, 1983). The relationship can be ended or altered by either individual. The mentor decreases the career and psychosocial functions by sponsoring from afar. Alternatively, a protege become a mentor to someone else during this stage. The protege may even emulate the mentor's best attributes. An interdependent relationship develops between the mentor and protege.

Professional Relationship Model

Dalton, Thompson, and Price (1977) described a theory of professional development that has four stages: apprentice, colleague, mentor and sponsor. During the apprentice stage, the protege learns under the close supervision of a mentor by helping others perform the job. In the second stage, the individual

learns to become an independent, competent contributor and peer or colleague to others. As the individual progresses to the third stage, he/she becomes a mentor contributing to the training of subordinates and assuming the responsibility for them. In the final stage, the individual affects the organization's direction and develops proteges through sponsorship. This model appears to allow the protege to revert to a prior stage if his/her role, job title, or career focus changes. The mentor and protege must be mature individuals for the model to have a positive impact on the organization as a whole.

Educational Model

Ross's (1984) model is a four stage professional development model in which mentoring plays an important role. The first stage is the individual's formal education process. The second stage occurs when the individual joins the practice world and develops a management style. Over a life-time, the third stage consists of continuing education in order to stay current and self-assessment to helps strike a balance between professional and personal values. The fourth stage occurs when the person reaches a point that they

strive for independence and must redirect his/her career path. Mentoring in this model does not accomplished by one individual. This latitude could provide the protege with a broader view of the professional environment. But at the same time, it could confuse and frustrate the protege if he/she is given divergent views on professional issues.

Mentoring as a Formal Organizational Program

A formal program can be established by the organization in which a mentor is assigned a protege. It can help the new employee feel more comfortable and ease the transition into the organization (Kilem, 1987). Keele, Buckner, and Bushnell (1987) proposed several characteristics of a successful formal mentoring program. It should be only a small component of a management development program for chosen fast-track proteges. Coaching is emphasized rather than mentoring the protege. The developing proteges are supported and rewarded by the organization. Selection problems could result from chosing only fast-track proteges, and coaching versus mentoring does not establish a long-term commitment to the relationship.

Farren et al. (1984) stated formal programs must

be monitored for potential problems. A protege who has unrealistic expectations about the program's importance in successful career development or a poor relationship between the assigned pair can be disastrous for them, as well as the organization. A mentor who does not have enough time for the protege or feels overburdened with too many proteges can be a potential problem. Developing a successful formal program could be accomplished by voluntary participation for mentors, minimizing the program's structural aspects, and allowing the mentor freedom in deciding the approaches to use in each mentor-protege relationship. The organization could create networks for the protege, share and negotiate the objectives and mentor/protege expectations, reward the mentor's effort, and include the supervisors in the relationship if possible.

Klauss (1981) recommended that organizations establish formal mentoring programs to assist the protege with the critical adjustments needed to move from one career/adult stage to another. Programs can provide interpersonal support that helps the protege make these transitions successful. Klauss derived several considerations when establishing and continuing

these programs. Potential mentors should be carefully chosen because not all upper level managers are natural mentors. The mentor should provide an environment that promotes openness, candor and mutual trust; show a readiness to invest time and energy in the relationship; and have a variety of experiences at various executive levels. Zey (1985) felt potential mentors should be established performers and respected throughout the organization. They should be interviewed, briefed on the program, and evaluated per set standards.

The protege should be involved in selecting his/her mentor. This establishes a personal bond and commitment between the mentor and protege to make the relationship work (Klauss, 1981). Burke and McKeen (1989) agree with Klauss and suggested that the following questions should be asked to increase the relationship's success. What is the mentor's level in the organization? Do the mentor and protege want to build a relationship? Do the mentor and protege offer each other something from the relationship? Does the pair have the interpersonal skills needed and understand their responsibilities in the relationship?

Zey (1984) further suggested that the mentor should examine several factors when chosing a protege. The mentor should consider a protege's intelligence, ambition, and loyalty, his/her desire and aptness to accept power and risk, his/her ability to perform the mentor's job and establish alliances, and his/her commitment to the organization. Factors to be considered in protege selection include: the protege's ability to comprehend the organization's culture, the congruency between the protege's and mentor's work and organization perception, and the organization's perception of the protege.

An orientation and training program explaining the goals and roles for the mentor and protege is critical (Burke & McKeen, 1989; Klauss, 1981; Zey, 1985). This eliminates any ambiguity that could interfere with the relationship. Interaction patterns and realistic expectations should be established to ensure a successful, productive relationship. Work schedule and time pressure factors must be examined so not to hinder the relationship (Klauss, 1981).

Dunbar (1990) suggested individuals should make appointments with middle or upper level executives in

attempts to cultivate a relationship. They should tell the potential mentor that his/her work is highly respected or volunteer for the mentor's projects. If the relationship does not develop, the individual must continue to search within or outside the company and if needed, the geographical area. Hennefrund (1986) suggested individuals should increase their visibility in the organization to attract a mentor or directly ask a person to be their mentor.

Keele et al. (1987) contend that the organization's culture impacted on a formal program's success, in that it could have a negative, rather than a positive effect on the employee's development. The authors compared formal programs with a social network and determined that a social network of various intensities and types and with various individuals could produce the same results as the formal program without the negative effects for the organization, protege, or mentor.

Mentoring as an Informal Organizational Component

After considering the factors of a formal program, the organization may assess the components of an informal mentoring program. In these programs, the

mentor and protege are not assigned, but establish the relationship themselves (Noe, 1988b). Farren et al. (1984) described informal mentoring as a phenomena in which the mentor usually initiates the relationship and the protege has low expectations and is grateful for the guidance received.

Noe (1988b) studied assigned mentors and proteges and determined that "organizations should not expect proteges to obtain the same type of benefits from an assigned mentoring relationship as they would receive from an informally established, primary relationship." His study suggested if an organization wants success in assigned relationships, then the organization must ensure accessibility to the mentor for the protege.

According to Reich's (1985) study, the majority of the respondents (83%) did not recommend formal mentoring programs. In their opinion, formal mentoring encouraged employees to become more preoccupied with organizational politics and less with job performance. Also, the findings demonstrated that informal mentoring occurs in most organizations and is effective in developing managers. To encourage a mentor's participation in the program, incentive systems should

be created. Bonus pay, increased pay, increased privileges, increased status, and possible promotion could be used (Jacoby, 1989).

Models in Medicine and Hospital Administration

Mentoring in the medical profession is usually an informal practice. A medical student, resident or physician will select someone they respect and admire to be their mentor. Often the mentor is not another physician, but someone who encouraged them to attend medical school. Moore (1989) found that students frequently named several individuals.

Lobeck and Stone (1990) described a formal mentoring program, in which one mentor, usually a senior physician teacher, was assigned to an entire class for the four years of medical school. The objective was assisting students to understand the practical importance of the information and concepts they learned and the role this plays in making complex clinical decisions. This successful program has been functioning for five years and has enriched, not only the students, but also the mentor.

Female physicians face the same cross-gendering problems as those in a business environment. According

to Ochberg, Barton, and West (1989), high-ranking male mentors, who are competent sponsors, were least likely to provide personal advice to their female proteges. Also, male mentors were less apt to promote their protege's equality and less sensitive to sex discrimination. But high-ranking female mentors did not have the same problems when assigned to male proteges. The authors suggested that young female physicians seek a high-ranking female mentor who can provide the sponsorship and personal advice the male mentor cannot.

Campoin and Goldfinch's (1983) study, aimed at determining the importance of mentoring to hospital administrators, found two-thirds of the sample had a mentor and had been a protege at some point in their careers. There were positive correlations between previous experiences with mentors, with the willingness to share knowledge, and with understanding and interest/involvement in mentoring.

Assumptions about Mentoring

Hagerty (1986) felt the unsubstantiated assumptions about mentoring made it difficult to explore the phenomenon. The first assumption is that a

mentor is a prerequisite for success. Many business articles reflect this assumption, but a cause and effect relationship has never been established.

Second, everyone should aim for success defined as an advanced degree or organizational advancement. Most research was conducted on high level executives and doctoral degree candidates without considering others such as staff nurses and clinical nurse specialists.

The third assumption is that mentoring is identical across professions, organizations and work settings. Mentoring in different settings must be tailored to its purpose, initiation and evolution.

The fourth assumption is that the absence of mentoring for women is the main reason for their lack of career advancement. This assumption has not been proven or disproven, especially in nursing.

Summary

In nursing, mentorship has a variety of definitions and has been adapted for use in the career advancement of educators, practitioners, and administrators. The next chapter defines mentorship in nursing and discusses the different applications and models developed by the profession.

Chapter 2

DEVELOPMENT OF MENTORING IN NURSING

Historically, nurses have not used mentors as a part of their career development process. It has only been within the last 10 years that the concept appeared in print. The reason may be that male mentorship models evolved out of male culture and experiences and the rules are reflected and understood in masculine terms. According to Campbell-Heider (1986), women's sex role socialization processes, in relation to career advancement, is opposite that of men and therefore the models are not easily adapted to traditionally female professions such as nursing. Women need a broad range of sponsorship models which are more compatible with these cultural attributes. Further, nursing must develop a profession specific model that encompasses the attributes and needs of its members.

Hamilton (1981) contends that women in general do not have a strong mentoring history. The socialization process of women toward affiliation and men toward competition may be the reason. Bardwick (cited by Hamilton, 1981) felt there is inconsistency in the role expectations for men and women. These expectations

have changed greatly in the last 10 years. In today's society, it is acceptable for a woman to be as career oriented as a man. She is no longer expected to be married and stay at home to raise a family. This may be a result of the economics of today's world.

Diamond (cited by Hamilton, 1981) contends that in a young girl's development, there is a lack of emphasis placed on competitive team sports. Team sports have been found to be a way to foster a boy's competitive spirit and leadership abilities. Conversely, girls are not expected to have designated winners or losers, have specific goals or explicit end point in their play. Although the number of team sports in high schools and colleges for women has grown, the number of professional sports has not. The sports available of that level remain to gentile type, for example figure skating and golf. In general, today, women are still encouraged to be less competitive than men.

In nursing, mentoring has different meanings. It is often equated with precepting or role modeling. Puetz (1987) described a continuum with role modeling at one end, precepting in the middle, and mentoring at the other end. Role modeling is a passive, but

effective, teaching method in which the nurse copies behaviors, both good and bad, exhibited by teachers, head nurses, or other staff nurses without grasping their purpose or rationale. The preceptor role is a more active relationship, but limited in scope and depth. In this situation, the preceptor teaches, supervises, and coaches the new nurse. This relationship occurs most often during orientation and does not continue once the nurse moves to another unit or hospital. The mentoring role is broader in depth and scope and can last many years. The mentor serves as a teacher, sponsor, host, exemplar, and counselor by sharing experiences.

Bidwell and Brasler (1989) stated that role modeling is an acceptable strategy in nursing education process, but short-term mentoring could be a strategy to assist the college senior and graduate student in making the transition to a new role. Mentoring is a long-term, personal, and emotional relationship that can be used by nursing faculty to educate promising students. Because of numbers, personalities and time factors, it is unrealistic for all students to have a faculty mentor. Mentoring could be used to assimilate

and socialize the individual to a new job, role, or expand his/her focus. The models in nursing (Figure 1) can be divided into four types: mentor, preceptor, role and career development.

Mentor Models in Nursing

Vance (1982) separated mentoring from role modeling and precepting. Although a mentor has the same functions, the crucial difference is the mentor believes in and blesses the neophyte's potential dreams for the future. As cited by Cooper (1983), Vance's mentor system trains and socializes the nurse to professional norms, values, and behavior standards; ensures continuity of leadership; and provides entry into the professional inner circle. The relationship can begin at any time, is on-going, lasts many years, and can provide the same benefits as in the business and medical realm.

Vance (1982) proposes that mentoring and parenting are similar. The relationship is intense, emotional, exclusionary and transitional. The mentor/parent reacts to the protege/child's needs by guiding and supporting them toward self-knowledge and independence. The relationship is intimate and personal requiring

Figure 1

Comparative Chart of Nursing Mentorship Models

Model	Length	Formal/ Informal	Role	Benefits	Risks
Mentor (Vance, Davidhizar)	Ongoing lasts years	Informal	Teach Advise Support Facili-tator	socializes builds confidence dec. stress more productive	over-protection from mentor personal risks if too open
Role Model (May et al., Williams & Blackburn)	None stated	Informal	Sponsor Advise Teach Assister Model	helps reach goals rehearses role clarify role assist with work	too many mentors no commitment from mentor process problems
Preceptor (Atwood)	4 wks. to 3 mons.	Formal	Teach Coach Inspire Support	Cost effective better patient care	Outcome problems
Career Development (Schim, Galbraith et al., Gunderson & Kenner)	None stated, could repeat	Informal	Teach Resource Support Nuturer Sponsor Counsel Facili-tator	Universal to all areas and roles Expectations are stated Protege developed slowly	No one mentor Mentor who can't separate from protege

generous amounts of time, energy, and material support. The protege/child grows with time, developing the self-confidence necessary to mature and become independent of the mentor/parent and hopefully becoming a mentor/parent themselves. Vance concluded that a "good" mentor/parent is a priceless asset to the protege/child's personal and career development. In this model, if the mentor is over-protective, the relationship will become dysfunctional and the protege will not mature and become independent. Also, this model implies that the mentor will instill personal values which the protege must have to uphold. This is not a mentor's role.

Davidhizar's (1988) model describes qualities a mentor should bring to the relationship. The mentor should bring a future directed orientation or, 'forwardness' to the relationship. The mentor must be more accomplished than the protege and share common interests in the nursing field, such as a mutual sense of direction, research issue, or a health care concern. From professional experience and expertise, the mentor must be able to advise and encourage the protege to develop career advancement strategies. The mentor and

protege must be able to trust and be willing to disclose personal information. The mentor must affirm and enhance the protege's self-esteem. This model describes the qualifications necessary to become a mentor, but it does not detail the overall mentorship process. It does not explain how the protege and mentor interact or the end point of the relationship. It would not be suited for general application to all areas of nursing because of these limitations.

Role Models in Nursing

May, Meleis and Winstead-Fry's (1982) mentorship model in doctoral education includes role modeling, role clarification, and role rehearsal. Role modeling involves observing another in action so to understand and emulate the behavior. Role clarification is understanding how different roles reap different benefits. Role rehearsal is practicing, imagining, and mentally enacting how a role might evolve. The authors included sponsorship, which has all the mentorship properties, that helps the protege find his/her "right spot." They felt that one mentor could not do it all, therefore the protege should seek out several mentors that can fit with a particular stage of career or

scholarly development. This model uses various techniques to develop and promote the protege. Role modeling is already used in nursing school and hospitals to instruct and orient neophytes. Graduate and doctoral candidates often use role clarification and rehearsal to determine their fit into the organization or new role. This model could be adapted to any level of nursing education or to any clinical or administrative path a nurse choses.

Williams and Blackburn (1988) conducted research and concluded that a collaborative model of mentorship predicted the research activity or productivity in academia. The model was role specific modeling/ teaching. The mentor's functions were to assist the protege in writing the grant proposal, in planning and conducting research, in finding funding sources, and in publishing the results, to include the protege in mentor's research, and to co-author a paper. This model does not describe the intensity level or personal commitment needed from the mentor or protege for a successful, lasting relationship. It describes a "cookbook" approach to the mentoring process. Therefore, it would be difficult to adapt the model to

the different areas of nursing.

Preceptor Models in Nursing

Atwood (1979 and 1986) describes a model closer to preceptorship than to true mentorship. The nurse mentor "teaches, coaches, inspires, and supports the development and growth of the team members, including staff nurses and at least one neophyte..." The mentor acts as a role model by performing the same nursing duties as the neophyte nurse and other staff members. The mentor works with the protege giving assurance and guidance and intervening in ongoing patient care when appropriate. This step lasts four weeks. During the subsequent months, the mentor assists a second nurse not experienced in the particular care area and rotates to night shift with the first protege, sharing patient assignments. Each nurse progresses rapidly, and by the end of three months the mentor has introduced two nurses to the unit. This type of orientation is more cost effective because the protege always takes a patient assignment. Also it individualizes support and recognizes the mentor's abilities. The patients receive better care, and the pair develops a special professional relationship. The program's goals are to

help the new graduate transition from student to nurse role and to assist the experienced nurse re-entering the field or changing settings. The model is a preceptorship called mentoring. It does not describe the mentor's functions after the orientation period ends or define the levels of intensity or commitment needed in the relationship. It only describes the mentor's functions in relationship to patient care, not to the protege's role and self development.

Career Development Models in Nursing

Schim (1990) adapted Dalton/Thompson's model of professional development discussed in Chapter 1 to the nursing environment. Stage I, apprenticeship, the nurse, under the direction and close supervision of an experienced nurse, learns to master the job's detailed work. Stage II, independent practice, the nurse becomes a colleague working with, not under, the mentor and receives less direction about patient care, but must inform the mentor of problems and their management of the patient. The nurse may choose a subspeciality during this stage and may remain at this development stage for the rest of his/her professional life. Progression to Stage III, mentorship, involves a

transition from colleague to mentor and to being responsible for the performance of others. The mentor influences, guides, directs, and develops other nurses by being a teacher, resource person, or manager. It is in this stage that the nurse-mentor decides to choose between a supervisory management and clinical preceptor role. Stage IV, sponsorship, the nurse moves from being responsible for other's performance to exercising power over the organizational environment for its benefit. At this stage, the nurse is usually in top management or a clinical nurse specialist. This model describes how mentoring fits into overall professional development, but it does not detail how it takes place or by whom. It does not explain how the mentor develops the protege's professional and career advancement strategies. Also, it does not describe the qualities necessary or the roles used to be a mentor. It does not address the protege's fit into the model. This model could be developed further to eliminate these weaknesses, at which point it could be easily adapted to a clinical or administrative environment.

Galbraith, Brueggemeyer and Manweiler (1988) detailed a mentoring model with the developmental

stages. Mentorship is not an assigned relationship, but develops out of mutual respect in this model. Stage 1 requires mutual, realistic, short-term goals be set for the pair. In stage 2, the protege seeks guidance about decisions, and in return, the mentor gives constructive criticism that fosters independence. Stage 3 sees the protege moving beyond the mentor's guidance to clarify and modify goals with colleagues and to analyze personal performance. In Stage 4, the growth stage, the protege starts to explore new knowledge and experiences and the mentor providing challenges that enhance growth without causing frustration. In Stage 5 or adult stage, the aim is to increase responsibility from and sponsorship by the mentor. The mentor's role is to facilitate autonomy. In Stage 6 or acceptance stage, the mentor provides the protege with new challenges that are more global in scope. The protege is finally accepted into the peer group and reaches maturity.

These authors do not address the milestones the protege must meet to move to the next stage. It focuses on the mentor's functions, but does not state specifically how they should be accomplished. It

implies that the process would begin anew with each mentor. If this is the case, the protege would never reach maturity. The model would be suited to the more mature protege and mentor pair. Therefore, it should not be used in undergraduate education or in early career development. It would be best suited to the graduate education process or advanced clinical/administrative practice.

Gunderson and Kenner (1988) adapted Urbano's (1986) developmental doctoral education model to a neonatal intensive care unit and showed how mentors can assist the protege during each stage. In the initial adjustment stage, the nurse is placed in an unfamiliar work arena with different, anxiety producing role expectations (Urbano, 1986). Called the creeping, crawling phase (Gunderson and Kenner, 1988), the protege tries to adjust to a new role and environment. The mentor nurtures, without being over critical, through positive reinforcement. By mastering and integrating the basic knowledge into actions, the protege can progress to the next stage.

In adaptation stage I, role expectations become clearer, socialization occurs, and bonds form with

colleagues (Urbano, 1986). Called sitting, standing phase, the nurse develops fine motor skills necessary to connect knowledge with practice. Hesitation and fear with independent decision making and feelings of inadequacy mark this phase. The protege consults the mentor concerning these decisions and before taking nursing actions. The mentor provides constructive criticism, counseling and support that helps the protege to move toward autonomy and to understand the complex diseases and nursing care needed in the unit. Role confusion and new job expectations can cause feelings of inadequacy leading the protege to regress to the previous phase. The mentor helps the protege complete a self-evaluation and provides realistic expectations that aid the protege in looking forward to the next phase (Gunderson and Kenner, 1988).

The adaptation stage II (Urbano, 1986) marks a change from a parent-child to a peer-adult relationship between the mentor and protege. In this stage, nurses begin to stand on their own. The stage is divided into the standing phase and the standing, walking phase. In the standing phase, the protege questions procedures and policies that are taken for granted by others,

becomes rebellious and acts out. The mentor must provide appropriate opportunities for further growth and development and must mutually set realistic goals with the protege. Added responsibility and independence demonstrate success and the protege's readiness to move forward. In the standing, walking phase, the protege seeks more responsibility and advancement opportunities. The mentor must risk giving the protege added responsibilities and act as a sponsor. The mentor must be an active participant in the learning process, must move from a teacher to a facilitator role, and must provide guidance and resources. This stage allows the protege to see failures and successes, promotes independence needed to build self-esteem and confidence, and builds respect and recognition from other nurses, thus moving the protege to the next phase (Gunderson and Kenner, 1988).

The termination stage (Urbano, 1986) is marked by the internalization of the new role and the ability to function independently from the mentor. Called the walking, running phase, it results when a good sense of identity is felt and the nurse is accepted into the peer group. Although more complex, there are still

questions. Because the unit may no longer stimulate learning, the mentor must find the protege new opportunities and ways to channel his/her energy into further growth and development. The protege could become a mentor, seek leadership positions, or return to school. The mentor must provide constructive criticism, support, and guidance through counseling. If this model and participants are successful, the protege becomes an independent, capable practitioner (Gunderson and Kenner, 1988). This model describes the role the mentor uses to develop the protege. It describes the milestones for progression through the model's stages. It allows for a change in focus or roles in one's nursing career and could be easily adapted to any area of nursing practice or education. It describes how the mentor and protege should interact, but not the roles the mentor should use to heighten the protege's development.

Roles of the Nurse Mentor

Darling (1984a) researched the characteristics nurses seek when looking for a mentor. Absolute requirements found were attraction, action, and affect that are demonstrated in various mentor roles.

The Inspirer, Investor, and Supporter roles are necessary for significant mentoring relationships. As an Inspirer, the mentor attracts the protege by being a Model, Envisioner, and/or Energizer. As a Modeler, the mentor is someone the protege admires, values, looks up to, and may emulate. The Envisioner conveys a professional goal, image, or vision that the protege finds personally meaningful. In the Energizer role, the mentor stimulates the protege through his/her enthusiasm or dynamism. In the Investor role, the mentor takes action on the protege's behalf because of his/her belief in them. In the Supporter role, the mentor provides encouragement and reassurance, instills confidence and fosters risk-taking, thus meeting the affect requirement.

The nine other roles describe various ways the mentor interacts with the protege. The mentor urges the protege to high standards of excellence as a Standard-Prodder. The Eye-Opener role broadens the protege's perspective via exposure to new ideas, concepts, and possibilities. As a Teacher-Coach, the mentor educates and guides; in the Feedback-Giver role, both positive and negative feedback are given to the

protege. As a Door-Opener, the mentor provides opportunities for career advancement. By discussing ideas, offering opinions, and being a sounding board, the mentor becomes an Idea-Bouncer. As a Problem-Solver, the mentor helps the protege examine and solve problems. As the protege in examines career issues, interests and choices, the mentor becomes a Career Counselor. Finally, by stimulating critical thinking, the mentor becomes a Challenger (Darling, 1984a).

Darling (1984b) feels different types of mentors are used depending on the protege's experience, needs, and career life cycle. The traditional mentor, an established, experienced professional, is older in years, offers wise counseling to the protege, and has considerable power and knowledge. Although closer in age and experience, a step-ahead mentor gives valuable advice to the junior protege. Co-mentors, peers closer in age and experience, provide mutual guidance and support to each other. A special form of a co-mentor, a spousal mentor, occurs between a husband and wife.

Nursing Research in Mentoring

Of the nurse leaders studied, Vance (1982 and 1989/1990) found that 83% had one or more mentors with

the majority being other nurses (70%) and female (79%) and 93% had served as mentors. The reported categories of help were career advice, professional role modeling, guidance and promotion, teaching/tutoring, scholarly/ intellectual stimulation, inspiration/idealism, and emotional support. Vance concluded a mentor plays a significant role in goal attainment, career satisfaction and professional commitment. Mentorships are vital to the profession.

Williams and Blackburn (1988) found that different forms of mentoring have different results. Role-specific modeling/teaching and a professionally stimulating environment correlated significantly with the protege's research activity and were the most effective types in the academic workplace. The other forms of mentoring, such as encouraging a dream, organizational socialization and advocacy, did not predict research productivity.

Cahill and Kelly (1989) developed a mentorship program that was modeled after a career development model. Then a pilot study was conducted comparing mentored and unmentored nurses. Many assumptions were made about the benefits for the protege and mentor.

They concluded mentoring was more critical to a woman's career development than thought in the past.

White (1988) studied mentoring of academic nurse administrators. The findings supported the assumption that mentoring is a developmental process that helps both the career development and advancement goals of young prospective academic nurse administrators.

Hamilton, Murray, Lindhom and Myers (1989) studied the effects of mentoring on job satisfaction/retention and leadership behaviors of the new nurse graduate. Mentored nurses were more satisfied with how their abilities were utilized, with hospital policy and procedure implementation, with the creative freedom afforded to them, and with the supervisory methods used. The study found that unmentored nurses tolerated freedom better and allowed subordinates a greater latitude for initiative, decision making and action over time. The retention rate for mentored nurse after a year was 100% versus 63% for the control group nurse. These findings support the need for mentorship in nursing to increase job satisfaction and retention. Also, the model should have a wider application to all levels of nursing practice.

Chapter 3

A MODEL FOR NURSING

This author uses the Gunderson and Kenner (1988) model as a basis for her model (Figure 2). Extending beyond the other models, they describes a maturer relationship between the pair and the roles each must play. Also, the author incorporates the mentor's roles and types described by Darling (1984a and 1984b).

The advantages of this combination are the ease of adaptation to any setting or position, the lack of time limitations to progress through the stages and the possibility of continuation of mentoring from afar. The model would be informal, as research has proven the negative effects of assigned mentoring. The author's model has been designed for incorporation into graduate education and nursing service administration.

Use in Graduate Education

At the graduate level, each clinical track cirricula should have leadership development with mentoring as a sub-topic. Using mentoring as a teaching method, the instructor encourages exploration of the thought processes and actions used in nursing practice. In the first stage, the instructor

Figure 2

Dixon's Mentorship Model

	Nurse Type	Protege's Development	Mentor's Roles	Mentor Type
Stage 1	New Nurse New Role New Clinical Area	Role adjustment Skill development Learns job tasks Develops decision making skills	Inspirer Modeler Supporter Teacher-coach	Traditional
Stage 2	As above Six months to a year in area or role	Clearer role expectations More independent in clinical area and performing tasks/skills Able to solve problems May orient newer nurses	Supporter Feedback-giver Problem-solver Energizer Idea-bouncer	Traditional Step-ahead
Stage 3	One year to five years in role	Explores advanced clinical practice Seeks increased responsibilities Independent in clinical area May need another mentor closer in role or clinical area	Envisioner Eye-opener Investor Standard-prodder Door-opener	Traditional Step-ahead Co-mentor
Stage 4	Advanced clinical nurse	Professionally mature Finds identity in area Asks more complex questions Conducts research Pursues advanced degree Becomes a mentor	Career counselor Challenger Envisioner Eye-opener Investor Standard-prodder Door-opener	Traditional Step-ahead Co-mentor Spousal

introduces a new concept, task or role and explains how it fits into future advanced clinical practice. In the second stage, the instructor steps back and allows the student to function more independently. As the student matures, the student is permitted more latitude in choosing adminstrative and clinical areas. The instructor fosters more independent thinking and decision making and encourages the student to expand his/her professional horizons in the third stage. As the student matures and takes on a new role in the fourth stage, the instructor advises and counsels in more a peer-like fashion. Using this model, students develop themselves more fully and the educational process is tailored to their needs.

The differences between mentoring, role modeling and precepting should be taught, so each nurse has a clearer picture of the role he/she plays at each career level. These are important concepts to understand because of the degree of commitment needed by the individuals and the intensity levels involved in the relationships. Also, the individuals must realize how to use each level to facilitate the learning process.

Use in Nursing Administration

The nurse administrator should develop mentors within the organization through education programs, one-to-one interactions, and being a role model to others by being a mentor. The dedication to mentoring as a method of retention, recruitment and education would be stated as part of the philosophy of the department. It also could be incorporated into nursing's goals and objectives. The nurse administrator could also recruit upper level managers that have the abilities and interpersonal skills to become mentors.

Each department chairperson could assist the unit managers in their development of mentoring skills through education and assessment of their interpersonal skills. The assessment of their knowledge about mentoring would be the first step, Then, the chairperson would determine which mangers and senior clinical nurses have the knowledge, interpersonal and leadership skills, and personal maturity and commitment to be an effective mentor. The unit managers would attempt to determine through interviews which staff members are willing and able to participate as proteges

in this model. The potential mentors and proteges would determine who they select. This would occur informally in each setting with the unit manager or chairperson identifying these individuals to the other.

An individualized educational strategy would be developed for managers and staff members. It could consist of informal round table discussions on mentoring's risks and benefits, the various models or stages, and the importance of mentoring to morale and clinical and managerial development of the staff. The assessment of interpersonal skills and leadership attributes could be accomplished through self and supervisory evaluation of potential mentors. Also, assessment tools, such as the Myers-Briggs, Hersey and Blanchard's, or a power base tool, could be used to determine their strengths and weaknesses. These findings would be incorporated into a personal developmental strategy for each potential mentor.

The department would allocate time and resources to those nurses serving as mentors. This could further be facilitated through formal recognition programs and/or incentive packages that focus on the mentor's contribution to the protege's development and progress.

The Stages of the Dixon Mentorship Model

Stage 1

This stage begins as the nurse enters a new role or practice arena or after a promotion or an advanced degree. Role adjustment takes place. The nurse learns the necessary job tasks, skills, and behaviors, and begins to develop the ability to make independent patient care decisions. The mentor uses the inspirer, modeler, supporter, and teacher-coach roles and is the traditional type during this stage. The mentor may or may not be the nurse's preceptor or supervisor and will consult with them as needed. Once the nurse grasps the skills/tasks needed to perform the job and demonstrates the ability to make independent decisions, he/she is ready to progress to the next stage.

Stage 2

In this stage, the nurse has clearer role expectations and begins to function more independently. He/she can successfully perform all related job tasks and skills. The nurse stills has questions, but begins to solve them on his/her own. The fear of making a mistake still remains, thus the nurse will continue to consult the mentor as needed. The nurse is begins

to feel comfortable in the chosen clinical area or role and may be orienting newer nurses. The mentor remains a supporter, but also becomes a feedback-giver, idea bouncer, problem-solver, and energizer. The mentor can be a traditional or step-ahead type. If successful and technically mature, the nurse moves to the third stage.

Stage 3

Professional development is this stage's focus. The nurse will seek continued education programs to explore advanced clinical practice areas. The advanced nurse pursues increased responsibility or an expanded practice role. He/she wants independence in practice, as well as a maturer relationship with the mentor. Using the envisioner, investor, standard-prodder, eye-opener and door-opener roles, the mentor assists the nurse with decisions about an advanced degree or expanded practice role. The mentor continues to be a traditional/step-ahead type, but may also become a co-mentor. To generate a broader experience base, the nurse may need more than one mentor in this and the following stage.

Stage 4

The protege reaches professional maturity and

finds an identity in his/her chosen practic area. The protege's questions become more complex and he/she may research the issue to find answers. The nurse is ready to pursue an advanced degree; the advanced nurse may seek a higher clinical or administrative position, a doctoral degree, or become a mentor to others. The mentor continues in the same roles as before, but also becomes a challenger and career counselor. The mentor type can be traditional, step-ahead, co-mentor, or spousal at this point.

Throughout the model, the relationship grows and matures, and may never end, even if the mentor and protege do not agree philosophically and clinically. There are time limitations and benchmarks for progression to the next stage. A nurse, who progresses to stage four and gets an advanced degree, may revert back to stage one and select a new mentor who has different credentials than the previous one. Because this is not an assigned relationship, the protege and mentor will be attracted to one another and develop a mutually agreed upon relationship. The relationship could evolve into a peer-like life-long friendship described in the business literature.

Chapter 4

IMPLICATIONS OF THE MODEL FOR NURSING ADMINISTRATORS

The literature review indicates mentorship can be used to nurture, educate, and socialize a new employee/protege to the job and its tasks, responsibilities, and politics. There are benefits and risks in the mentor relationship (Burke, 1984; Clawson and Kram, 1984; Myers and Humphreys, 1985; and Thomas, 1989). The mentorship models (Dalton et al., 1977; Hunt and Michael, 1984; Kram, 1983; and Ross, 1984) do not fully consider the benefits and risks and are not readily adapted to other professional settings. Although a formal program decreases selection problems, it has many more process and outcome problems than an informal program (Farren et al., 1984; Noe, 1988b; and Reich, 1985). Because an informal program is more widely accepted and desired by the mentor/protege pair, it is the preferred arrangement.

Recently nursing has explored mentoring as a method to teach and to socialize the neophyte to the nursing culture (Davidhizar, 1988, Gunderson and Kenner, 1988; and Schim, 1990). Many authors (Atwood, 1979 and 1986; May et al., 1982; and Puetz, 1987) have

interchanged preceptorship and role modeling with mentorship. This has resulted in confusion and ambiguity in fitting mentorship into the organization, professional nursing development, and the mentor's role in the relationship (Darling, 1984a and 1984b). Mentoring can have a positive affect on the protege and mentor in terms of career development (Cahill and Kelly, 1989), job satisfaction, and leadership behaviors (Hamilton et al., 1989).

From the literature review and the author's experience, the models presented have many limitations. They do not address the risks of mentoring, are a more formal, have assigned relationship, and are limited in scope and intensity. The models reviewed did not resolve the selection, process, and outcome problems completely; neither did they address the specific roles the mentor plays in the protege's development; and they are not easily adapted to all levels and areas of nursing.

To reap the benefits from mentorship, nursing must develop a comprehensive, informal mentorship model that can be adapted to any clinical, educational, or administrative setting. The author's model blends and

expands two different nursing models and addresses the limitations found in the literature. The model can be used in the educational, leadership development, and career development process. For mentoring to be successful, the nurse administrator must consider the following factors: 1) the organizational fit with and commitment to the process, 2) the impact of the arrangement on the organization, 3) development of performance objectives, 4) the necessary education, 5) the mentor/protege selection process, 6) the piloting and implementing of the model, 7) the evaluation process, and 8) a reward and recognition program.

Determining Organizational Fit and Commitment

Prior to implementing the model, the nurse administrator must assess the organizational climate to determine the fit of mentoring within it. Also, the degree of commitment to mentorship as a tool to development the employee's career and a tool for use in retention and recruitment (Keele et al., 1987). A model's organizational fit and its influence in meeting needs are criteria upon which to select a model. If mentoring is perceived negatively by the organization, strategies must be developed accordingly to change

these perceptions. The strategies must address the risks, benefits and assumptions about mentoring, the different mentoring models, an' how the model could be implemented.

To demonstrate the Nurse administrator can demonstrate their commitment to the staff's professional development by serving as a mentor themselves. Also the identification of upper level executives and/or those in an academic setting who could serve as mentors would further show the commitment to mentorship (Dunbar, 1990).

The department's philosophy and objectives should reflect the commitment to mentorship as a means to develop nurse leaders within the organization. Also a specific plan should be outlined to implement a chosen mentorship model. By making a formal statement, the administrator makes known the model's purpose, objectives, structure and fit within the organization.

Organizational Impact

Using mentorship as a professional/leadership development tool could have a positive impact on image, recruitment, retention and related costs and produce a quality professional/managerial team (Zey, 1984).

Through commitment to nurse development, the organization improves its image with staff and the community. As a marketing and recruitment strategy for the institution, mentorship could serve as a means of administrative and clinical advancement. Retention increases by showing how an individual progresses and develops through the program and how advanced education and changing roles fit into the individual's overall career advancement. This model is cost effective because it is easily incorporated into the present orientation process (Jacoby, 1989).

Because of its versatility, the model can be used by the institution for developing nurses with various educational and experience levels, thus producing a quality patient care team (Zey, 1984). Nurses can move back and forth through the stages as their role changes. If the model was implemented, nurses would be placed in the stage that corresponds to their educational and experience level (Dalton et al., 1977).

Developing Performance Objectives

The nurse administrator must set forth specific performance objectives for department chairpersons and unit managers pertaining to mentoring as a critical job

attribute. The objectives would be measurable and clear regarding the number of proteges each should have and the role the mentor plays. This is determined individually in coordination with the mentor and their related job responsibilities. This reduces the risk of spending too little or too much time on the protege's development (Zey, 1984). The mentor would be responsible for expanding the protege's learning opportunities and if necessary, with the individual's preceptor (Gunderson and Kenner, 1988).

Developing an Educational Program

Mentorship is not a concept readily understood by nurses (Puetz, 1987). The nurse administrator must assess the staff's knowledge level and develop an educational program about the mentorship model. This decreases their anxiety and fear.

As part of the new employee's orientation, the mentorship model's goals, objectives and stages should be discussed and illustrated. The developmental stages and the specific skills, tasks, and abilities that must be mastered to progress to the next stage needs to be discussed (Gunderson and Kenner, 1988). The mentor's roles and types would be further defined (Darling,

1984a). This eliminates ambiguity and decreases fear about the model and its function within the individual unit and organization (Klaus, 1981 and Zey, 1985).

Mentor/Protege Selection Process

Different levels of nurses - - clinicians, administrators, and educators - - can play different roles in this model. The senior clinician could be a potential mentor for nurses pursuing a clinically based nursing career, such as a clinical nurse specialist or practitioner, and for nurses that are just beginning nursing as a career. The administrator could mentor a nurse who has chosen an administrative track, such as a head nurse role, or recruitment or professional development track. The nurse educator could mentor nurses in an undergraduate, graduate or doctoral level program. They could encourage using research as a method for exploring new patient care techniques or solving problems. A fellowship program could be developed to pair potential proteges with mentors of a specifically chosen track. Using all types of nursing disciplines encourages a more thorough development of the potential proteges. Also, it helps develop the necessary professional commitment that has

been lacking in nursing history.

The mentor and protege selection process must be outlined. Each manager's mentoring abilities would be determined. Those with strong interpersonal skills and managerial abilities would be used as the cornerstone for the beginning the program. The administrator must be careful to be objective, using specific criteria when selecting potential mentors to avoid the many mentoring risks (Myers and Humphreys, 1985 and Thomas, 1989). The unit managers and chairperson should work together to identify mentors among the staff.

If only a few mentors are selected, the administrator must develop strategies to expand other senior clinical and administrative nurses' managerial and interpersonal skills so they can be mentors. These individuals would be developed through educational programs and skills assessment by using the managerial tools previously mentioned.

During the hiring process, the administrator should identify mentoring as a job duty and determine the potential employee's ability to participate in the process. The specific performance objectives would be outlined in the job description. The model could be

used as a method to orient the employees to their jobs and develop performance objectives further.

Once mentors have been selected, a process to select proteges must be instituted. Not everyone can be a protege or mentor. Those with a commitment to the relationship and desire to participate would be selected as a potential protege (Zey, 1984). The potential protege must be willing to invest energy in the relationship. A good fit between the pair is a prerequisite to the relationship's development and is a basis for mutual attraction and trust.

If there are limited mentors available, potential proteges must be identified at the beginning. As mentoring becomes an important concept to nursing, the number of mentors and proteges will grow, and therefore the pairing process becomes less limited and more informal.

The nurse administrator would set forth in the objectives that the mentor and protege would be informally paired. This eliminates many risks inherent to formal assigned mentoring, such as preselection and blatant discrimination (Myers and Humphreys, 1985; Noe, 1988b; and Reich, 1985). If administrators use a

formal pairing, they must develop an assignment strategy that is objective, fair to all participants and avoids the selection, process, and outcome problems previously mentioned (Burke and McKeen, 1989).

Informal mentoring can be accomplished by the administrator, chairperson, and unit manager identifying potential mentors and proteges. Then, each mentor would be given information about the proteges and asked to select one that he/she could work with and develop. As mentoring becomes part of the organizational culture, a more informal selection process can be used in pairing mentors and proteges.

The mentor and protege must determine the relationship's objectives, thus personally tailoring the relationship to their needs. These objectives determine to amount of time and commitment necessary to make the relationship successful. To avoid dependence of the mentor and eliminate outcome problems, performance standards and development benchmarks for progression through the model's stages must be set by the pair and the unit (Zey, 1984). These are crucial implementation steps.

The nurse administrator must be careful not to

discriminate when selecting potential mentors and proteges. As stated previously, selection problems exist with the mentoring process. Therefore, a committee or a similar selection process must be in place to prevent this from happening. It could be through committee process or through interviewing various individuals to identify mentors and proteges. Those individuals that are repeatedly named could be selected as mentors. As the model is fully implemented, every individual should be viewed as a potential protege. Also, those selected as mentors would have varying numbers of proteges, as dictated by their abilities and time constraints.

Piloting and Implementing the Model

The administrator should select a department/unit that has a high number of potential mentors or on which the staff is mature to test and refine the model. The unit should be encouraged to adapt the model as needed to their individual and group needs. Their changes should be evaluated and changes to the model should be made if they do not discriminate against staff members.

The nurse administrator must set forth a timetable for the model's implementation for the remaining units

in the organization. Each unit would set specific plans to develop potential mentors and proteges. The department could implement a plan that would allow divisions/units to share proteges and mentors, especially if there limited numbers of mentors available in a particular area. This promotes inter-division/unit collaboration, as well as, an expanded view of the department for both the mentor and protege. Also, this would allow the mentors to have proteges that are not potential subordinates and vice versa. By exposing mentors and proteges to other clinicians and/or administrators within the department, broader perspectives may be acquired.

Evaluation Process

Once this model was implemented, research could be done to determine its effectiveness on the professional and educational development of the proteges (Cahill and Kelly, 1989). An assessment of the effectiveness of the model on the unit, protege, and mentor should be conducted after the model has been in placed for six months to a year. This could be done by surveying mentored and unmentored nurses and testing their clinical knowledge and decision making skills. The

effect on recruitment could be researched during the interviewing and hiring process. Staff could be asked what determined their decision to apply for a nursing position at the institution. The model's effect on nurse retention could be determined by analyzing turnover rates before and after the implementation of the model. Also, by interviewing the nurses participating in the model, the administrator would determine its effectiveness and if changes need to made. This would ultimately determine if the model would be implemented on the other units. Surveys on job satisfaction could be conducted with mentored and unmentored nurses to determine the model's impact and if changes are necessary. If these results are positive, they could be used in recruitment efforts, as well as a community advertisement method to bring patients into the institution. The impact on the quality of patient care could be determined via the nurse's performance and conducting quality assurance studies pertaining to the care given and patient satisfaction with this care.

Rewarding and Recognizing Participants

In the developing stages of this model, the

administrator may consider an incentive plan to encourage nurses to participate as a mentor. This may include monetary or other compensation methods, such as duty time without patient care or administrative responsibilities to meet with the protege. A formal recognition program could instituted to increase the program's status and visibility in the other hospital departments and in the nursing community (Farren et al., 1984).

The protege must also be recognized and receive praise from upper levels in the organization. Positive outcomes for the protege through this model include: enhanced self-confidence and self-respect, and ultimately greater career satisfaction and success.

By formally recognizing both mentors and proteges, the model gains more visibility and may be a catalyst in encouraging participation from others in the organization. Those nurses that do not have mentors will seek out individuals that can serve as a mentor either through the unit or their personal outside contacts. The administrator must actively seek out potential mentors from educational and other clinical/administrative settings within the community

or from outside personal contacts. It is important that the administrator and the organization search for mentors for all employees that desire one so favoritism does not become an issue.

Conclusion

Mentorship can have a tremendous impact on the nursing profession and its development. The process may lead to enhanced self-esteem and greater job satisfaction for both the mentor and protege. These positive outcomes in turn may help in establishing a more positive social climate and in encouraging others to commit themselves to a mentor-protege relationship. Identifying to ultimate impact of the relationship should lead to effective nursing care. More extensive research to determine the direction and strength of the interacting variables that shape the model needs to dome. Mentorship could be a key factor in the future of the nursing profession.

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